PAINFUL EAR NODULE OF WINKLER AND FOERSTER*

REPORT OF CASES

By GEORGE D. CULVER, M. D.
San Francisco

DISCUSSION *by Laurence R. Taussig, M. D., San Francisco; H. J. Templeton, M. D., Oakland; Samuel Ayres, Jr., M. D., Los Angeles.*

WINKLER should be given credit for first calling attention to this distinctive pathological condition of the auricle.[1] Foerster deserves credit likewise for having called attention to it without knowledge of Winkler's work, designating it "painful nodular growth of the ear." [2] The term applied by Winkler, "chondrodermatitis nodularis chronica helicis," may impress one as cumbersome. It could well be shortened by leaving out "chronic." Sequeira selected "keratoma auriculare." [3] Nothing, however, could be simpler or more direct as a name than "painful ear nodule."

PATHOLOGY

Since attention was called to the condition by Foerster and by Winkler it has been found to be a much more frequent occurrence than was apparently first thought. Many physicians must have seen and treated painful nodules of the ears in the past, without having so classified them. In looking over records antedating the work of Winkler and Foerster I found notes describing fairly definitely the condition, and yet I must have had only a hazy mental picture of it. Since then, while on the outlook for such lesions, I have found them, and have had the opportunity to try different methods of treatment. An instance of a decided failure with a case in 1915, which was treated with temporary success two years later, helped to clarify my idea of the lesion.

Foerster's description is worth repeating: "An ovoid or circular well-defined nodule, varying from three to ten millimeters (usually less than five) in its longest diameter, embedded in the skin or elevated several millimeters above the surface, and in most instances found to be immovable and firmly attached to the cartilage. The nodule is flat-topped or convex, with sloping sides, and it often has a deep or shallow central depression filled in by a more or less adherent crustlike scale. Removal of the scale discloses either an irregularly cupped depression or a pinpoint to pinhead-sized defect or area of ulceration with a red and moist base. The nodules may be skin-colored, grayish, rose red, yellowish or waxy and somewhat translucent, bearing at times a resemblance to epithelioma. A narrow zone of hyperemia is occasionally seen around the lesion and, except for this, the adjacent skin is normal in appearance." [4]

The cutaneous and subcutaneous changes have proved to be inflammatory when the dermatologist's attention is called to the defect, usually chronic to the extent of definite nodular thickening topped by keratotic changes in the epithelium, the keratosis often covering a central point of ulceration. The inflammatory process extends to and involves the perichondrium and chondrium. Many features of the lesion, which can be seen while it is being removed, as well as the reaction of the area of the ear to treatment, would seem to indicate something fairly definite in the etiology.

Though the location is most frequently that of the region of "Darwin's point" of the ear, which on most ears is the sharply curved posterior superior portion of the border of the helix, an exact replica of the pathologic change can occur on the helix anterior to or below this point, or upon the antihelix, particularly when the antihelix is prominent in its outward projection beyond the border of the helix.

It is not the purpose of this paper to go into the histologic study of painful ear nodes. It would be difficult to more clearly describe the pathologic findings than has been done by Foerster,[4] Rost,[5] Roxburgh,[6] Dubreuilh,[7] and recently by Mierowsky.[8] Other points of interest would seem to warrant careful consideration, however.

Not until Foerster's original article was read before the American Dermatological Association was it our habit to segregate instances of painful ear nodules as they were not then recognized as a clinical entity. Since 1918 there have been twenty-six typical instances in the practice of Doctor Montgomery and myself.

REPORT OF CASES*

CASE 1.—Mrs. A. P., female, forty-three, housewife, a former patient with ichthyosis, had a minute tender keratotic topped nodule on the edge of the helix of the right ear at its upper posterior curve (usual location). The tenderness was the main feature. The small keratosis with the soft tissue under it was curetted, and trichloracetic acid was applied to the base. Healing was perfect, leaving a smooth surface. Two months later there still remained some tenderness, but the skin covering was intact and smooth. There was an interval of two years, during which time the tenderness had persisted, and another nodule had formed. Because of the previous failure to remove the tenderness the soft tissues were cut through and nearly one centimeter of the edge of the cartilage was trimmed off with scissors to a depth of about two millimeters. The removal of the rim of cartilage was prompted by its sharpness and the fact that it felt rough and was tender beyond the limit of the nodule. A cure was apparently obtained. Ten years later, however, tenderness developed posterior to and below the former scar. More of the edge of the cartilage was trimmed off, with resultant freedom from discomfort. There was nothing in the history of this case pointing to the cause of the disturbance.

CASE 2.—J. P., male, forty-two, physician, had for about a year a painful nodular keratotic-topped lesion on the antihelix of the right ear near its bifurcation. It was fairly circular at its base with a diameter of about five millimeters. The lesion was curetted, trichloracetic acid was applied to the base and it was subsequently irradiated with radium. The wound healed, but the pain and tenderness persisted. Not until a further more radical removal of the scar area, with curettage of the underlying cartilage, did the tenderness disappear.

In this instance the antihelix projected markedly outward beyond the border of the helix, and the painful nodule included the most prominent point. The patient was a sound sleeper and, for as long as he could remember, it had been his habit to sleep on his right side with the affected ear pressed closely to the pillow. His attention was first drawn to the condition by the tenderness.

* Read before the Dermatology and Syphilology Section of the California Medical Association at the Fifty-Eighth Annual Session, May 6-9, 1929.

* A statistical analysis of the twenty-six cases of this article will be appended to the author's reprints.

CASE 3.—W. B., male, sixty, merchant, had a painful nodule of the right ear on the helix anterior to Darwin's point which he thought was caused by a puncture made several months previously to obtain blood for examination. The nodule gave rise to the usual discomfort from lying on a pillow. The patient had serious cardiac trouble with marked circulatory disturbances.

The nodule was reamed out with scissors, the edge of cartilage was trimmed off and the edges of the wound were pulled together with narrow adhesive plaster strips; boric acid powder dressing was applied. Apparently a cure was complete, and there has not been a recurrence.

CASE 4.—J. M., male, sixty-five, physician, had a small keratosis on the top of a small painful nodule situated on the helix of the left ear in the usual location. The nodule was curetted and the base was cauterized with trichloracetic acid, after which radium was applied. There were four recurrences, three of which were similarly treated with only temporary relief. After removing the cartilaginous edge there was an apparent cure.

There was no clear history of the time of beginning or of the possible causation in this case.

CASE 5.—C. P., male, seventy, retired business man, had a painful nodule on the helix of the left auricle near the tip which had appeared about one month before. It was curetted and cauterized, then irradiated with radium. It was a success for the three years that it was possible to follow the case.

There was no history of possible causative factors.

CASE 6.—B. R., male, only twenty years old, began two years previously to develop painful nodules on both ears. He had, when I saw him, seven such nodules on the right ear, and six on the left. He was not treated. (Figs. 1 and 2.)

He said his ears had been frozen when he was a child. He was subject to chilblains and his ears were deep bluish red.

CASE 7.—J. W., male, fifty-six, railroad employee, came to me because of two painful tender nodules on his left ear, one below and one anterior to a scar over the helix at its upper posterior curve. The scar was the result of excision of a painful nodule one year previously. Both nodules were curetted under novocain anesthesia, the edge of the cartilage beneath each one was trimmed off, and the wound was closed. Healing was uneventful.

There was nothing of interest in the history of this case.

CASE 8.—E. P., male, thirty-six, stockman, had a "pillow" painful nodule of the apex of the helix of the right auricle which had been developing more than a year. The nodule was curetted, the edge of the cartilage underneath was trimmed off, and trichloracetic acid was applied. The wound healed. Three months later the patient returned, complaining of tenderness anterior to the scar. There was slight crusting over the tender area but no definite nodule. This was similarly treated. Again in three months, then a fourth time after two months, and a fifth time in another two months, he returned, each time with tenderness farther along the edge of the helix anteriorly and below. Altogether nearly three centimeters of the edge of cartilage was trimmed off before all of the tender area was removed.

There was no doubt in this case that the tenderness was in the sharp knifelike edge of the helix of this man's ear.

There was nothing of interest in his history pointing to the development of the original lesion.

CASE 9.—H. W., female, thirty, had for one year a typical painful nodule of the right auricle on the antihelix below its bifurcation. At its top was a small thick circular keratosis about two millimeters in diameter. This was curetted and the base was cauterized. One month later, after perfectly smooth healing, the tenderness was still present. The scar area was opened and a circular piece of cartilage about three millimeters in diameter was trimmed out. A month later, because of persistence of tenderness, the procedure was repeated and more of the cartilage was removed. Apparently the third operation was successful, as it has been possible to observe the subsequent result.

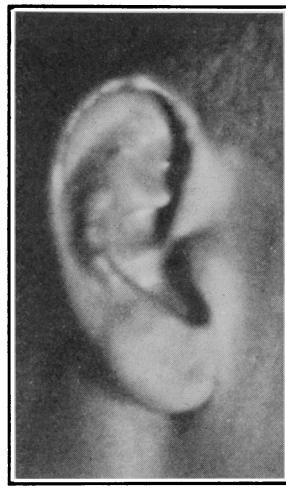

Fig. 1.—Painful nodules on helix and antihelix of right ear. Man twenty years of age.

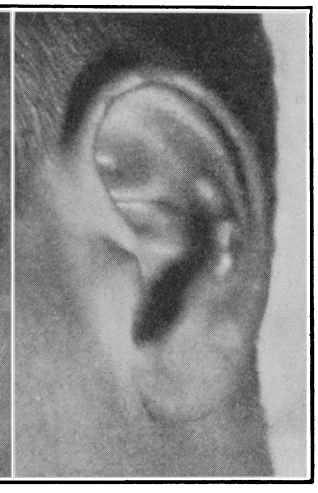

Fig. 2.—Painful nodules on helix and antihelix of left ear. Man twenty years of age.

In this instance the antihelix was prominent, extending laterally beyond the border of the helix, and the nodule was on the most prominent portion. Close-fitting hats, pulled tightly over the ears, caused marked discomfort. She attributed the lesion to the wearing of a tight-fitting rough straw hat every day for three weeks while traveling in an open automobile one year previously.

CASE 10.—W. B., male, sixty-one, bank employee, had a painful nodule on his left ear, situated in the usual area on the helix, about half a centimeter long. It had been present seven years. There was a history of recurrent crusting. The nodule was topped with a central keratosis. The keratosis covered a small droplet of yellow pus. Under novocain anesthesia the nodule was slit open along the edge of cartilage. At the base of the pus pocket a small split-pea sized cup-shaped piece of cartilage was found detached from the rim. The helix presented a saw-tooth edge three-quarters of a centimeter in length. This edge was decidedly brittle. About two centimeters of the cartilaginous rim, including the part with the notched edge, was trimmed off with scissors to a depth of about two millimeters. All granulation tissue in the soft parts was curetted, the wound was soaked with alcohol, the edges were pulled together with thin strips of adhesive plaster leaving spaces between, the area was covered with boric acid powder, and a small gauze dressing was applied with adhesive plaster. Within five days healing was complete. This was apparently a success.

No definite history preceding the appearance of the nodule could be obtained.

CASE 11.—C. M., male, about sixty years old, had a painful hyperkeratotic lesion of the right ear in the usual location on the helix. The nodule, which had been present many months, was removed and the edge of the cartilage was trimmed away. Twenty months later the patient again came into the office, this time with a sluggish abscess in the situation of the scar where the cartilage had been removed. This was opened and the pocket, which was filled with creamy-white pus and semisolid necrotic tissue, was emptied. Careful drainage has been continued for

weeks without lessening of the daily discharge. This patient has been under observation nearly six months, during which time there has been progressive loss of cartilaginous substance, giving a noticeable flattening of the upper curved portion of the auricle. He presents a problem which has not yet been solved. The radiographer, pathologist, and bacteriologist have been unable to give any definite aid. The *Staphylococcus albus* has been found in almost pure culture. Constitutional faults of a tangible character, such as possible specific backing or cardiovascular derangements, are negative. Radical surgery may be the only resort, but even that may be of relative value only, depending upon the extent of ear-shell removed. Every means is being tried to save the upper portion of the ear.

Three cases with typical painful nodules in the common location, No. 12, a man fifty-seven years old, with one on the right ear; No. 13, a woman forty-five years old, with one on the right ear; No. 14, a man sixty-one years old, with one on the right ear, in all of which there was no apparent secondary infection, were treated experimentally. This was to prove to myself that the rim of cartilage was of prime consideration in the matter of successful end-result. Under novocain anesthesia the tissues of the nodules over their edges of cartilage were incised with the scissors, and in each instance, without removing any of the soft tissue, the cartilaginous edge was trimmed off a little more extensively than seemed to be indicated, and the wound was closed. In all three cases this procedure was apparently all that was necessary, as healing followed, tenderness disappeared and the areas assumed normal appearances.

Cases 15 to 26 inclusive presented typical painful nodules with little of special interest. They are considered in the statistical analysis.

Doubtful cases with painful ear lesions that are not included in the list, and some of which date back more than twenty years, must have been examples of painful ear nodes. There were twenty-three of these among our older records.

One record, dated 1910, of a man fifty-four years old, a physician, had these notes: "A keratosis on the rim of the left ear-shell that has been present several months. It pains when he lies on it. Lesion curetted and trichloracetic acid applied to base. There is venous stasis of the edge of the earshell so intense as to simulate a Reynaud."

On a record, dated 1906, of a man fifty-three years old, are these notes: "Lesion began two months ago on the margin of the top of the right earshell. It is now a small bean-sized growth, constricted at the base, with rounded sides, and it has a crusted top. It might readily be mistaken for a molluscum contagiosum. On curetting, the lesion proved to be much deeper than I anticipated."

Such records were found among those classified originally under "senile keratoses," later with an omission of the word "senile" for obvious reasons.

SUMMARY OF REPORT

Location of Lesions.—Of the twenty-six patients affected the location was at or near the upper posterior curve of the helix (Darwin's point) in by far the greater number. There were twenty-one who had a single painful nodule in this location. One had a nodule on each ear. One presented two nodules separated by a scar. One other had multiple nodules on both ears. There were sixteen instances in which the right helix was involved and ten with the left. The antihelix was affected four times, singly on the right ear in two instances, and the patient with multiple nodules had them on the helix and antihelix of both right and left ears.

Instances in Women.—The rarity of women patients with painful ear nodules may be only of passing interest. I have seen three. Would the factor of lessened exposure be brought to mind, and may not this accentuate exposure in the male to rougher elements and to rougher handling? I have thought that possibly a woman's ears are more protected because of the heavier mass of hair. Having the rarity of this condition in women in mind I have sought for other reasons. By comparison women's ears seem to have more subcutaneous tissue over the ridges than is usually found in men's ears, and men's ears seem to have more prominent Darwin points.

Etiologic Factors.—This brings up the question of likely etiologic factors. It is surprising what a small proportion of the cases give any tangible or even conjectural history preceding the occurrence of the nodes, and this in spite of the fact that a patient usually feels quite positive he knows the underlying cause of every swelling or growth.

The location of the node on the most exposed part of the auricle points definitely to irritation as a factor to be considered. And perhaps the commonest and most frequently repeated irritation is that of the pressure of the ear upon the pillow in sleeping. Unfortunately it was determined in only a few instances whether or not the habit of the patient had been to lie on the affected side. A woman's mass of hair may prevent much of the close pressure of the ear against the pillow that a man's closely cut hair does not. Long-continued pressure of the ear against the pillow for hours at a time while the patient is sleeping must in many instances interfere with free circulation of the most exposed area, and so deprive the subjacent cartilage of its nourishment. Now that most women have short hair we may see more frequent instances of painful ear nodes among them. However, even now they wear much more hair than do middle-aged men. It would be unfair to refer to the tight ear-pinching headgear commonly worn by women as an etiological factor, though it was unquestionably an exciting cause of pain in one instance here reported. Previous freezing of the ears in which chronic circulatory deficiency results is no doubt important, and the auricle, which at best is subject to insufficient nutrition, becomes more faulty in later years, especially when cardiovascular pathology has begun.

It seems to me that circulatory faults in the soft tissues over the helix and antihelix and in the subjacent perichondrium must be of paramount importance in producing an impoverished cartilaginous rim. Roxburgh has given an excellent description of the cartilage pathology.[6] In Case 10 the cartilaginous changes had progressed to the extent of causing the separation of a small piece of cartilage and definite degeneration of the approximating rim, giving it a saw-toothed appearance. Secondary infection was a factor in this case, but probably not the sole cause of the degeneration.

It is perfectly consistent that recurrences should take place in those instances in which all of the faulty cartilaginous rim is not removed, and it is difficult to determine just how much should be

removed. Also recurrences should be the rule in those patients in whom the same circulatory faults continue or are continually produced. I have gained the impression that most of the patients I have seen have a fairly definite realization of the possibility of a recurrence. They certainly have not been a fault-finding group.

The young chap who had two painful ears, with seven tender nodules on the right ear and six on the left, as shown in the photographs, gave a positive history of having had his ears frozen. He also was subject to pernio of the ears, and when I saw him he had congested bluish red ears. The history he gave was worthy of note as all the occurrences were fresh in his memory. (See Fig. 1 and Fig. 2.)

Some question might arise as to whether or not the nodules in this patient were of the same histologic structure as others reported. No positive proof can be offered as the patient was not treated. The condition was unique in my experience. None of the nodules resembled tophi and the patient was only eighteen years old when they began. Keratotic thickening of the epithelium had begun to form on the tops of some of them, not on all. The tenderness to pressure was marked. Each individual nodule fitted well into the picture presented by other instances at some stage while under observation. I had not any doubt that the nodules were clinical examples of chondrodermatitis nodularis chronica helicis. In fact this case seemed to strongly indicate the primary development as occurring in the cartilage.

Treatment.—The character of the nodule in the individual case governs the treatment very largely. The important consideration is as to how best to remove all of the pathologic tissue. Whatever method accomplishes this will prove temporarily successful. It is not difficult to work under novocain anesthesia. All the chronic inflammatory soft tissue process can be easily removed by curetting, if so indicated, or by cutting it away with sharp pointed scissors. The rim of cartilage or area of cartilage underneath should be carefully trimmed away, guessing to the best of one's ability as to what extent. If the wound is cauterized it should be permitted to heal by granulation. No doubt in some instances cauterization is best. I have found it advisable in most of the later cases not to cauterize the wound but to soak it with alcohol and then pull the edges together with fine strips of zinc oxid adhesive plaster, leaving spaces between the strips. Stitching might easily irritate the already faulty area. The whole area can be covered with boric acid powder, and a small gauze dressing fastened on with adhesive plaster. Usually healing is uneventful.

CONCLUSIONS

The painful ear nodule is a distinctive dermatological entity. Pain on pressure is the dominant symptom. The nodule consists of chronic inflammatory changes in the soft tissues.

Frequency.—It must be a much more frequent occurrence than one would judge by the number of reported cases.

History.—The history of the beginning of the lesion is characterized by its indefiniteness. All positive information gained, points to circulatory faults.

Age.—The only significance age has, and it is none the less important, is that the development is at the time of life one would expect degeneration to manifest itself. Only four of the patients were under forty, and there was a fairly even division in the grouping into the fifth, sixth, and seven decades.

Sex.—Evidently not many women have painful ear nodules. There were twenty-three men and only three women in the list of twenty-six. And in the list of case records not used, but which were probably instances of painful ear nodules, there were no women. This would indicate a still greater preponderance among men. A woman may be protected by her mass of hair acting as a cushion about the ears, and possibly by having less prominent Darwinian points and greater padding of soft tissue over the edges of cartilage.

Etiology.—Tangible factors would seem to point to circulatory deficiencies in the immediate locality of the painful nodule. The most common disturbance results from pressure of the auricle upon the pillow in sleeping. The gradual development which takes place over a long time would account for the paucity of the history obtained in instances due to that cause.

Essential Change.—The essential change in the painful ear nodule insofar as treatment is concerned must be the pathologic change that has taken place in the cartilage. This change is quite constant in its location in the most exposed and least well-nourished portion of the auricle, most commonly the edge of the helix at Darwin's point, but also of the antihelix when most exposed to pressure. Over this is formed the nodule of inflammatory soft tissue, with keratotic changes in the epithelium at the top.

Relationship of Time of Disturbance in Soft Tissues and Cartilage.—This point is difficult to determine. The persistence of the tenderness over the cartilaginous structure, even after the affected soft tissue is removed and healing has taken place, would seem to point to the possibility of degeneration of cartilage first. This faulty rim or area of cartilage may act much as would a foreign body or as a sequestrum of bone acts in its irritation of the soft tissues in contact with it. Infective microörganisms must play a purely secondary rôle.

Possibility of Failure in Treatment.—One cannot foretell this possibility of failure. The very nature of the etiologic faults would presuppose such a possibility.

Recurrence.—Recurrence does not always mean faulty treatment or faulty judgment, I hope. We are dealing with a condition which, like a headache, may be a "comeback" under similar circumstances.

Possibility of Epitheliomatous Changes.—There was not a single instance of epitheliomatous degeneration in the list of twenty-six. In most of the cases the patients sought relief fairly early.

However, there were some of extended duration without such an eventuation.

323 Geary Street.

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DISCUSSION

LAURENCE R. TAUSSIG, M. D. (384 Post Street, San Francisco).—Painful ear nodules are not rare, and it is important to recognize them in order to institute effective treatment. Probably the most striking clinical feature aside from their location is the marked tenderness. I believe that the most important factor in their development is pressure very likely associated, as Culver has pointed out, with circulatory disturbance. Apparently in each case there is a piece of loose cartilage acting as a sequestrum and as such causing the irritation. The failure to find and remove this sequestrum is, in my opinion, the reason for not obtaining a cure. The method of treatment is immaterial. Sharp dissection, curetting with or without subsequent cauterization, cautery excision, or electrothermic methods are all satisfactory providing the sequestrum is removed.

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SAMUEL AYRES JR., M. D. (517 Westlake Professional Building, Los Angeles).—There is very little to add to Doctor Culver's clean-cut analysis of this not uncommon malady. I have had one instance in a woman in whom the condition was first noted following the wearing of a close-fitting hat.

In the matter of treatment I have had success with carbon dioxid freezing, and more recently with diathermic coagulation under novocain. I have not been aware of recurrences with these methods.

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H. J. TEMPLETON, M. D. (3115 Webster Street, Oakland).—I have one female patient suffering from painful ear nodule. She is twenty-seven years old and works as a mannequin trying on modern tight-fitting hats all day long.

It is my opinion that in her particular case trauma has been the etiologic factor. I have treated all of my cases by rather wide excision with the actual cautery.

The point that Doctor Culver makes in regard to there being a cartilaginous sequestrum present which must be removed is of great practical interest.

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DOCTOR CULVER (Closing).—I wish to thank the men who have discussed my paper.

There is one point that would seem to bear a closing remark even though it may be considered a repetition. The faulty cartilaginous edge is not necessarily free, and it may not give any evidence when it is laid bare that it is pathologic. One has to take it for granted that it is so and use his best judgment as to how much of it should be removed.

Since reading the paper I have seen a boy twelve years of age with a painful nodule of three years' duration on the right ear in the usual location, typical even to the hyperkeratotic top. One was developing also on the left ear, still presenting a smooth surface, and only slightly tender. There was an absence of any history of trauma. Trauma does not seem to be a necessary factor in its causation.

THE LURE OF MEDICAL HISTORY

AN OLD BOOK BY BENJAMIN RUSH

By GILBERT R. OWEN, M. D.
Los Angeles

OF Benjamin Rush much has been written, and, as a signer of the Declaration, he is probably one of the best known among American physicians. Historically, how little a century means; yet who among us would appreciate his pre-Pasteurian titles of the "American Sydenham" or the "Pennsylvania Hippocrates."

The book of which we write is a delightful little volume bound in the conventional calf of the period, and from the press of Thomas and Samuel, descendants of the famous William Bradford, who opened the first American press; and the little volume is our excuse for these sketchy comments on Benjamin Rush.

"Essays—Literary, Moral and Philosophical" is the rather depressing title of the volume. It is charmingly and quaintly dedicated: "As a record of fraternal affection, the following essays are inscribed to Jacob Rush, Judge of the Third District of Pennsylvania, by his friend and brother, the author. January 9, 1798." The essays embodied are of the most protean character, and are a fair index of the feeling of civic responsibility common among prominent physicians in Colonial days. Most of the essays had appeared in the *Columbian Magazine*. They won for him caustic comment from Holmes. Garrison terms him "A typical eighteenth century theorist, and a man whose social propagandism against war, slavery, alcoholism, and the death penalty was perhaps not entirely dissociated from a personal interest in increasing his practice."

As a "cure" for the tobacco habit may be read the opening paragraph of "Observations Upon the Influence of the Habitual Use of Tobacco Upon Health, Morals and Property." It is reminiscent of the pictures of the alcoholically induced, hobnail-liver which were in the textbooks of our youth. We are sure that no nicotin addict will care to continue the regrettable habit after having read it: "Were it possible for a being who had resided upon our globe to visit the inhabitants of a planet where reason governed, and to tell them that a vile weed was in general use among the inhabitants of the globe it had left which afforded no nourishment—that this weed was cultivated with immense care, that it was an important article of commerce, that the want of it produced real misery, that its taste was extremely nauseous, that it was unfriendly to health and morals, and that its use was attended with considerable loss of time and property, the account would be thought incredible, and the author of it would probably be excluded from society for relating a story of so improbable a nature. In no one view is it possible to contemplate the creature man in a more absurd and ridiculous light than in his attachment to Tobacco."

There are some amusing highlights in his homily, a sprinkling of wisdom; but nothing of therapeutic value. Let us read as we run.